

Responsible Male:

Name: James Ivan MASTERSON Relationship to Youth: Father ID 10
 Street Address: 11718 N. Ninth Street
 City: Tampa County: Flonda State: Florida Country: Zip: 33612
 Phone: (813) 977-6891 Date of Birth: 06/30/36 Social Security Nbr: 410-52-8789
 Race/Ethnic: W Date of Death: 1/18 Employed: Yes No Current Marital Status: D
 Abused as Child: Yes No Unknown Rared in Chaotic Environment: Yes No Unknown
 Poor Relationship with Own Parent: Yes No Unknown
 Poor or No Peer Relationships: Yes No Unknown

FAMILY

Marital Status of Birth or Adopted Parents:

- Never Married (1) Married (2)
 Father Deceased (5) Mother Deceased (6) Divorced (3)
 Both Deceased (7)

 Separated (4)

If adopted, what does child know about birth parents? _____

Parental Rights Terminated: Mother: Yes No Father: Yes NoIs family or significant person willing to participate in treatment during youth's placement? Yes No

If yes, who: _____

Are there prohibitive factors to this person's involvement? Yes No

If yes, explain: _____

Does the Family Have: Health Insurance? Yes No
 A.F.D.C Benefits? Yes No

Eligible for Medicaid? Yes No Currently Receiving Medicaid? Yes No
 Doctor: _____ Address: _____

Siblings:

Name	Date Of Birth	Relationship
Sherry MASTERSON Wager	01/09/58	SIS
Terry " Tantera	03/17/59	SIS
James Ivan " J.R. MASTERSON	03/15/60	bro
Ramona " Weiss	03/24/62	SIS
Christopher " MASTERSON	10/10/67	bro
Joseph Ralph " MASTERSON	01/15/68	bro
Frances " (ADM)	01/18/71	SIS
Richard Allan "	03/05/72	B.S.H.

Characteristics of All Family Members with Whom Youth Has Lived:

	No	Somewhat or Sometimes	Very Much or Often	Unknown
a. Chronic Poverty	<input type="checkbox"/> -0	<input type="checkbox"/> -1	<input checked="" type="checkbox"/> -2	<input type="checkbox"/> -?
b. Chaotic Home Environment	<input type="checkbox"/> -0	<input type="checkbox"/> -1	<input checked="" type="checkbox"/> -2	<input type="checkbox"/> -?
c. Violent Toward Family Members	<input type="checkbox"/> -0	<input type="checkbox"/> -1	<input checked="" type="checkbox"/> -2	<input type="checkbox"/> -?
d. Suicide	<input type="checkbox"/> -0	<input type="checkbox"/> -1	<input checked="" type="checkbox"/> -2	<input type="checkbox"/> -?
e. Alcohol or Drug Problems	<input type="checkbox"/> -0	<input type="checkbox"/> -1	<input type="checkbox"/> -2	<input type="checkbox"/> -?
f. Criminal Behavior	<input type="checkbox"/> -0	<input type="checkbox"/> -1	<input checked="" type="checkbox"/> -2	<input type="checkbox"/> -?
g. Involving a Child in Criminal Behavior	<input type="checkbox"/> -0	<input type="checkbox"/> -1	<input checked="" type="checkbox"/> -2	<input type="checkbox"/> -?
h. Mental Retardation or Limited Intellectual Ability	<input type="checkbox"/> -0	<input type="checkbox"/> -1	<input checked="" type="checkbox"/> -2	<input type="checkbox"/> -?
i. Mental Illness or Disability	<input type="checkbox"/> -0	<input type="checkbox"/> -1	<input type="checkbox"/> -2	<input type="checkbox"/> -?
j. Physical Illness or Disability	<input type="checkbox"/> -0	<input checked="" type="checkbox"/> -1	<input type="checkbox"/> -2	<input type="checkbox"/> -?

Abuse or Neglect of Youth by Parent or Parent Surrogate:

	No	Somewhat or Sometimes	Very Much or Often	Unknown
a. Physical Abuse	<input type="checkbox"/> -0	<input checked="" type="checkbox"/> -1	<input type="checkbox"/> -2	<input type="checkbox"/> -?
b. Sexual Abuse	<input type="checkbox"/> -0	<input type="checkbox"/> -1	<input type="checkbox"/> -2	<input type="checkbox"/> -?
c. Emotional Abuse	<input type="checkbox"/> -0	<input checked="" type="checkbox"/> -1	<input type="checkbox"/> -2	<input type="checkbox"/> -?
d. Abandonment, Extreme Rejection, or Extreme Neglect	<input type="checkbox"/> -0	<input type="checkbox"/> -1	<input type="checkbox"/> -2	<input type="checkbox"/> -?

Family Dynamics:

	Very	Minimum	None
a. Rigid, Inflexible	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Smothering; Individualization of Members is Discouraged	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Enmeshed; Few Outside Involvements	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
d. Discipline Skills Lacking	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
e. Difficult or Unacceptable to Express Emotions	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
f. Frequent Family Moves or School Moves	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
g. Child Moved from One Parent/Family Member to Another	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Level of Concern with Psychosomatic Complaints	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
i. Social Isolation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Probation Officer: M. L. Gutierrez (713) 521-4129

Name

Phone Number

4-28-88

Date

TYC Caseworker's Signature: JL 5/5/88

Date

FATHER: James Ivan Masteron	DOB/PLACE: 6/30/36 Tamm			
ADDRESS: 1171 B N. Ninth St., Tampa, Florida	ZIP: 33602			
EMPLOYER: 7/1/1 Old Lady's	PHONE: n/a			
LENGTH: HOURS: ANNUAL NET INCOME: n/a	OCCUPATION: n/a			
SOC. SEC. #: 410-52-8789 ALIEN #:	DR. LIC.#:			
MOTHER: Elizabeth Ann (Burnett) Masterson	DOB/PLACE: 9/29/36 Tamm			
ADDRESS: 1331 Herkimer Court	ZIP: 33608			
EMPLOYER: 7/1/1	PHONE: 864-2938			
LENGTH: HOURS: ANNUAL NET INCOME: n/a	OCCUPATION: n/a			
SOC. SEC. #: 410-54-2324 ALIEN #:	DR. LIC.#: 0235-9808			
GUARDIANS/CUSTODIANS/S-PARENTS/F-PARENTS/H.C.C.P.S., D., T.Y.C. AND M.H.M.R.A.				
NAME: _____	NAME: _____			
ADDRESS: _____	ADDRESS: _____			
ZIP: _____	PHONE: _____			
DOB/PLACE: _____	DOB/PLACE: _____			
EMPLOYER: _____	PHONE: _____			
EMPLOYER: _____	PHONE: _____			
ANNUAL NET INCOME: _____	ANNUAL NET INCOME: _____			
OCCUPATION: _____	OCCUPATION: _____			
SOC. SEC. #: _____	SOC. SEC. #: _____			
PARENTS MARITAL HISTORY:				
Father To:	Date/Place	# Children	Status	Date/Place
C. Burnett	11/3/57 Trenton Ga.	8	SDI	
	after numerous separations they		SDI	1985
			SDI	
			SDI	
Mother To:	Date/Place	# Children	Status	Date/Place
Jane Masterson	11/3/57 Trenton Ga.	8	SDI	
	after numerous separations they		SDI	1985
			SDI	
			SDI	
# Other Children: Child Support: yes/no Court: Child Support Paid By:				
SIBLINGS (in birth order):				
NAME	ADDRESS	SCHOOL AND GRADE	DOB/PLACE	
1. Sherry Masterson Wagner	Tampa Ind.		11/9/58	
2. Terry " Tamm	" "		3/17/59	
3. James J. Masterson Jr.	TDC		3/15/60	
4. Ramona Masterson Weiss	1331 Herkimer road ind.		3/24/62	
5. Chris Masterson	TDC		10/11/67	
6. Joseph "	Cajun - poss TDC		11/15/68	
Revised: 10-24-86 Original Index			18/7/71 15/17/73	

Seizure Disorders and Trauma*

WILLIAM F. FALLON, JR., MD, LINDA M. ROBERTSON, MD, and RAYMOND H. ALEXANDER, MD, Jacksonville, Fla

ABSTRACT: The prevalence of seizure disorder diagnosis in the general population is between 0.5% and 2.0%. Seizures may be manifested by abnormal motor activity, loss of muscle tone, and changes in mental status. Seizure may increase an individual's risk for traumatic injury by adversely influencing performance in a particular situation. We identified 30 patients admitted to our trauma service over a three-year period with injury related to seizure; 16 were male and 14 were female, with a mean age of 34.8 years. Twenty-eight patients (93%) had a history of seizure activity, with the mean duration of seizure activity of 16.5 years (range, three to 40 years). Both seizure diagnosis and etiology were multifactorial. Multiple drug therapy predominated, phenytoin (Dilantin) being the most frequently used medication. Overall compliance was poor (53%). Only blunt injury occurred in these patients, 50% suffering injury from falls. Injuries from motor vehicle accidents (40%) were the next most frequent (auto crash in seven cases, motorcycle crash in four, and bicycle crash in one case). The remainder of the injuries were burns (10%). Nine patients (30%) required operation. Skeletal injuries predominated (67%). Patients with a history of seizure will be frequently encountered by physicians of all specialties. The patients likely to be at increased risk for injury are noncompliant, have breakthrough seizures (ie, despite therapy), or have the metabolism of their seizure medication altered by alcohol or other drugs. To prevent potentially serious injury, these patients should be identified and counseled.

DEATH AND DISABILITY due to injury remains the single most important disease process below the age of 40.^{1,2} The epidemiologic analysis of injury can identify factors predisposing to an increase in the frequency and risk of injury. The epidemiologic model used for this purpose describes the traumatic event as the transfer of energy to a victim under a certain set of conditions.³ Certain chronic diseases may alter the victim's susceptibility to injury if they decrease the person's functional level at a time when such a decrease would interfere with appropriate interaction with the environment.

One such condition that may affect both the risk and rate of injury is seizure disorder. The prevalence of seizure disorder diagnosis in the general population is considered to be between 0.5% and 2.0%.⁴ Seizures may be manifested by abnormal motor activity, loss of muscle tone, and change in mental status. The duration of these changes can vary, and return to normal functional capacity may be delayed. Seizure activity may increase an individual's risk for injury by adverse-

ly influencing performance in a particular situation. Both the frequency of injury and its severity may be different for the person with seizures than for the population at large.

Our purpose in this study was to determine the relationship between seizure disorder, frequency of injury, and severity of injury in our trauma population so that we could determine the risk for these patients and identify a mechanism for decreasing this risk.

The Trauma Service of the University of Florida Health Science Center (Jacksonville) maintains a comprehensive data base on each patient admitted to the Trauma Service. Our center is a level 1 facility serving a region of the state with a population base of 1.2 million. During a three-year period, there were 30 admissions to the Trauma Service in which a history of seizure activity was identified. This represented 1.6% of all the admissions for that period. These patients form the basis of this report.

Patients sent to our Trauma Center are received in a special five-bay resuscitation center where a multidisciplinary team, led by an experienced trauma surgeon, performs initial stabilization and treatment. Priority is given to rapid aggressive resuscitation with airway control, ventilation, and intravenous fluid replacement. Diagnostic evaluation is done almost simultaneously, with roent-

*Read before the Section on Surgery, Southern Medical Association, 82nd Annual Scientific Assembly, New Orleans, La, Nov 1-4, 1988.

From the Department of Surgery, Division of Trauma Services, and the Department of Medicine, University of Florida Health Science Center, Jacksonville.

Reprint requests to William F. Fallon, Jr., MD, Department of Surgery, University Hospital of Jacksonville, 655 W Eighth St, Jacksonville, FL 32209.

TABLE 1. Mechanism of Injury (n = 30)

	No. Patients
Fall	15
Motor vehicle accident	7
Motorcycle accident	4
Bicycle accident	1
Burn	3

Mean Injury Severity Score = 7.7. All injuries were blunt trauma.

genographic assessment of appropriate structures. A detailed history is then obtained from the patient, prehospital service personnel, and available family members. This history includes the identification of allergies, chronic illnesses, and use of any medications, illicit drugs, or alcohol, as well as establishing when the patient last ate, and the events leading to the accident. In the case of medication use, compliance with prescribed dosages is judged to be important. Injury severity is assessed using the Abbreviated Injury Scale⁵ (AIS-85), and an Injury Severity Score is determined using the AIS-85 after the method of Baker et al.^{6,7}

All 30 patients admitted to the Trauma Service with the diagnosis of seizure disorder by history had sustained blunt trauma. The male-female ratio was 1.15:1.0, and the mean age was 34.8 years. In 28 patients seizure activity was directly implicated as the initiating variable in the traumatic event. Falls caused the trauma in 50% of the cases. Motor vehicle accident was the next most frequent cause, followed by motorcycle crash, burns, and bicycle crash (Table 1). Vehicular accidents accounted for 40% of the injuries seen. Injury severity was low, with an average Injury Severity Score of 7.7 (range, 1 to 25).

Operative procedures were necessary in nine of the 30 patients (30%), with repair of skeletal structures predominating (Table 2). There was no mortality in this series. Length of hospital stay averaged 7.13 days (range, one to 35 days). Twenty percent of patients required treatment in the intensive care unit (ICU), with an average ICU stay of 3.3 days; one third of these patients required intubation and mechanical ventilation in the ICU.

TABLE 2. Operative Procedures

Orthopedic	3
Oral-maxillofacial	3
Neurosurgical	1
General	1
Burn surgery	1
	9 (30%)

TABLE 3. Seizure Disorder

Type of Seizure	No. Patients
Partial complex	7
Tonic-clonic	5
Petit mal	2
Grand mal	2
Generalized	1
Focal	1
Simple/partial (new onset)	1
Adult onset	1
"Epilepsy"	1
Unknown	9

Of the 30 patients, 28 had a previous history of seizures.

Twenty-eight of the patients (93%) had a history of seizure immediately before injury. Seizure diagnoses were varied, the most frequent being "partial complex"; type of seizure was unknown in nine (30%) (Table 3). In no instance was the diagnosis of any disorder more specific than "seizure history" helpful in the initial management of these trauma patients. The mean duration of seizure activity was 16.5 years (range, three to 40 years). Twenty-six patients (87%) had had documented seizures before the seizure that led to injury, and one third of these patients (9/26) additionally were noted to have had breakthrough seizure activity (ie, despite anticonvulsant therapy) before the seizure leading to the injury. Fifteen patients had been hospitalized because of their last seizure, and ten had been injured during the last seizure.

These patients were taking a variety of seizure medications (Table 4). Multiple drug therapy predominated, though adequate drug levels were infrequently documented at the time of resuscitation. Overall compliance was judged to be poor in 16 of the cases (53%). Seven of the patients (23%) had a history of breakthrough seizure activity, defined as seizure occurring during anticonvulsant therapy. There were no new-onset seizures responsible for trauma in this review. Six patients (20%) were found to have alcohol in the blood at the time of resuscitation. Seizure medication was

TABLE 4. Seizure Medications

Drug	No. Patients	No. With Adequate Blood Levels
Phenytoin (Dilantin)	25/30	4
Phenobarbital	15/30	5
Carbamazepine (Tegretol)	5/30	2
Primidone (Mysoline)	2/30	1
Clonazepam (Klonopin)	1/30	Unknown
Valproic acid	1/30	Unknown

TABLE 5. Morbidity/Mortality Data

Mortality	0
Morbidity	4
Colostomy	1
Paraplegia	1
Paresis, right upper extremity	1
Gait dysfunction	1

changed in one third of the patients at the time of discharge. No deaths occurred in the seizure-trauma group. Four patients (13%) left the hospital with some functional impairment, which was clearly temporary in one and long-term or permanent in three (Table 5).

DISCUSSION

Patients who have a seizure-related injury form a subset within the trauma population identifiable by its demographics. The importance of this is twofold. First, seizure disorder is a host factor associated with a clearly definable risk for injury. Second, identification of seizure as a possible cause of the injury should suggest strategies for prevention. Returning to the epidemiologic model of trauma, three components are involved: the agent, the host, and the circumstances. Energy is always the agent—kinetic energy in the case of blunt trauma and falls and thermal energy in the case of burns. It appears that the most important mechanism for energy transfer in patients with seizure disorders is the change in susceptibility for injury in any given environment when compared with individuals without seizure history. Indirect evidence for this assumption from our study is the patient profile identified in our review. The average age from our review was older than the usual mean age we have identified in previous reviews. Additionally, the injury mechanism was exclusively blunt trauma, again not typical for retrospective reviews from our data base. The most striking finding is the approximately equal male-female incidence. This is extremely unusual, and further defines this unique population. The importance of identifying groups at high risk for injury is that the factors causing this group to be at high risk can be further defined for planning strategies aimed at prevention. Further analysis of our seizure population identified several such

factors. First, all 30 patients demonstrated problems with their medications; there was a clear trend toward noncompliance, 16 (53%) having been judged as only poorly compliant. Adequate levels were documented at the time of resuscitation in only 25% of the patients whose levels were measured. Seven patients had a history of breakthrough seizures, and in our population, this probably is a sign of poor compliance as well. Twenty-six patients (87%) had several seizures, one third of them just before the seizure leading to admission.

The goal in our analysis of injury related to seizures is to develop guidelines to prevent injury by reducing risk, typically by education, enforcement, examination, and environmental modification.³ Recognizing the inverse relationship between injury and the extent of active participation in prevention methods,⁸ antiseizure regimens should be as simple as possible to promote compliance.⁹ Physicians of all disciplines should educate such patients as to their risks for injury and should recognize those who, by their seizure activity pattern, are clearly at an increased risk. Drug levels should be monitored frequently in these patients. Using the epidemiologic model that regards injury as a disease, we have analyzed those patients with a clear risk for injury occurrence. We encourage physicians of all specialties to participate in a program of prevention designed to reduce the frequency and severity of trauma in this group of individuals.

References

- Trunkey DD: Trauma. *Sci Am* 249:28-35, 1983
- Baker SP: Injuries: the neglected epidemic. *J Trauma* 27:343-348, 1987
- Baker SP: Determinants of injury and opportunities for intervention. *Am J Epidemiol* 107:98-102, 1975
- Orlowski JP, Rothner AD, Lueders H: Submersion accidents in children with epilepsy. *Am J Dis Child* 136:777-780, 1982
- American Association for Automotive Medicine. The Abbreviated Injury Scale, 1985 revision, Arlington Heights, IL 60005
- Baker SP, O'Neill B, Haddon W, et al: The Injury Severity Score: a method for describing patients with multiple injuries and evaluating emergency care. *J Trauma* 14:187-196, 1974
- Baker SP, O'Neill B: The Injury Severity Score: an update. *J Trauma* 16:882-885, 1976
- Baker SP: Childhood injuries: the community approach to prevention. *J Public Health Policy* 2:235-246, 1981
- Wilder BJ: Treatment considerations in anticonvulsant manotherapy. *Epilepsia* 28(suppl 2):51-57, 1987

Neurologywww.neurology.org

doi: 10.1212/WNL.39.8.1037

Neurology August 1, 1989 vol. 39 no. 8 1037

Articles**Seizures associated with recreational drug abuse**

Brian K. Alldredge, PharmD, Daniel H. Lowenstein, MD and Roger P. Simon, MD

[Author Affiliations](#)**ABSTRACT**

We retrospectively identified 49 cases of recreational drug-induced seizures in 47 patients seen at the San Francisco General Hospital between 1975 and 1987. Most patients experienced a single generalized tonic-clonic seizure associated with acute drug intoxication, but 7 patients had multiple seizures and 2 patients developed status epilepticus. The recreational drugs implicated were cocaine (32 cases), amphetamine (11), heroin (7), and phencyclidine (4). A combination of drugs was responsible in 11 cases. Seizures occurred independent of the route of administration, and occurred in both first-time and chronic abusers. Ten patients (21%) reported having had prior seizures, all with a close temporal association with drug abuse. Other than 1 patient who developed prolonged status epilepticus that caused a fixed neurologic deficit, most patients had no obvious short-term neurologic sequelae.

© 1989 by AAN Enterprises, Inc.

Articles citing this article**Pharmacological Management of Seizures and Status Epilepticus in Critically Ill Patients**

Journal of Pharmacy Practice October 1, 2010 23:441-454

[Abstract](#) [Full Text \(PDF\)](#)**Clinical Utility of an LC-MS/MS Seizure Panel for Common Drugs Involved in Drug-Induced Seizures**

Clin. Chem. January 1, 2009 55:126-133

[Abstract](#) [Full Text](#) [Full Text \(PDF\)](#)**Seizures and substance abuse: Treatment considerations**

Neurology December 26, 2006 67:S45-S48

[Abstract](#) [Full Text](#)